DATA BASE: HISTORY

IDENTIFYING DATA (Use patient’s initials, not full name)

CHIEF COMPLAINTS

HISTORY OF PRESENT ILLNESS (Problem by problem)

A. The Biomedical Perspective (The disease):

B. The Patient’s Perspective (The “Illness”):
PAST MEDICAL HISTORY

Significant Childhood Illnesses:

Immunizations:

Adult Illnesses/Hospitalizations:

Psychiatric Illnesses/Hospitalizations

Operations:

Injuries/Accidents:

Obstetric History:

Transfusions:
CURRENT HEALTH STATUS

Medications:

Allergies/Drug Reactions:

Health Screening:

Diet, Sleep, Exercise:

Habits:

   Tobacco -

   Alcohol -

   Drugs -

   Alternative Therapies

PSYCHOSOCIAL HISTORY

Marital Status:

Living arrangements/Family Structure/Domestic Violence Screening:

Employment:

Occupational Exposures:
Sexual History:

Significant Life Events:

Mental Status:

<table>
<thead>
<tr>
<th>FAMILY HISTORY</th>
<th>AGE</th>
<th>ILLNESS DURING LIFE/AGE at DEATH &amp; cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
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<tr>
<td>Father</td>
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<tr>
<td>Each Child</td>
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<tr>
<td>Each Sibling</td>
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REVIEW OF SYSTEMS

General:

Skin:

Head:
Eyes:

Ears:

Nose and Sinuses:

Mouth and Throat:

Neck:

Breasts:

Respiratory:

Cardiac:

Gastrointestinal:

Urinary:
Genitoreproductive:

Male -

Female -

Musculoskeletal:

Peripheral Vascular:

Neurological:

Psychiatric:

Endocrine:

Hematologic: